STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	390147	A. BLDG: 00 B. WING:	06/22/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENN HIGHLANDS MON VALLEY STATE LICENSE NUMBER: 137001	1163 COUNTRY CLUB ROAD MONONGAHELA, PA 15063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 0000	INITIAL COMMENT This report is the result of a special monitoring survey conducted on June 22, 2023. The facility attestations for the following were reviewed: Varicose Vein Treatment RF and Cyanoacrylate C2 (Coronary) Shockwave AmWell Telemedicine Platform (Telemedicine Cart/Tablet) Addition of Craniotomies to Neurosurgery It was determined the facility was in compliance with the applicable requirements of the Pennsylvania Department of Health ' s Rules and Regulations for Hospitals, 28 Pa Code, Part IV, Subparts A and B, November 1987, as amended June 1998.	P 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Certified End Page

PENN HIGHLANDS MON VALLEY

STATE LICENSE NUMBER: 137001

SURVEY EXIT DATE: 06/22/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY